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He writes that Wood discloses "a suction catheter system that is designed to remove blood, irrigation liquid" during a surgical procedure. Mr. Stigell does not understand any of the limitations of this device. One with ordinary skill in this art would understand that you cannot take a marginal wound-vacuum suction which is what Wood's device is and somehow conceive of my device in light of Pell's device or Joseph's invention. The structures a wound suction contacts are particular and delicate as mentioned above and they include the fine vascular and neural structures that a fractions of a millimeter in diameter. It also depends on the size of the wound. Its uses, design and limitations are not for the oropharynx, supraglottic and subglottic spaces or the tracheal or distal bronchial structures. It is like looking at a shop-vac in your garage and using it to invalidate the patent protection of all suctions that have specific medical uses in particular areas of the human anatomy. That is how related Woods device is to my device and to the other devices. Again as stated, Mr Stigell does not have the knowledge or technical skill in this art to render and opinion on what someone with ordinary skill in this art would be able to construct in light of three unrelated devices he has cited so his rejections are not valid and should be withdrawn.

The device from Joseph as I mentioned ad nauseum previously to the examiner, functions to remove a few if that milliliters of tracheal secretions to improve tracheal hygiene in intubated patients. It is desgined to irrigate the area of the proximal trachea only to remove excessive accumulation of fluid in the proximal trachea only. It has no designed apparatus to allow for suctioning and more importantly it is not designed for any removal of debris from the distal trachea or the

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oropharynx. Someone with ordinary skill cannot in any conceivable way look at the this device "in light" of Pell and Wood and somehow clearly develop a functional device to clear the oropharynx, proximal trachea, distal trachea, proximal bronchi and distal bronchi.

I present for the appeals board why I have ordinary skill in this art. I graduated at the top of my medical school class from a United States medical school. I was selected to the medical honor society. I scored a 99% on my US medical licensing exam, one of the most difficult professional licensing exams in the world. I served as the chief of my residency. I was selected to surgical and emergency medicine training programs at two of the top hospitals in our nation. I practice this art every day of my life. I have studied this art at the highest level through 10 yrs of graduate medical training and now practical experience as an attending physician in some of the top hospitals in the world.

I can estimate what ordinary skill in this art as well as extraordinary skill. What did I know about ordinary skill in this art after obtaining an undergraduate degree in biology(nothing). What did I know about ordinary skill in this art after obtaining a Doctor of Medicine degree? (at least something, but not ordinary skill) I covered the physiology and anatomy of the human body with rigourous detail and was able to assist physicians in implanting these devices in live patients in the operating room. What did I know about ordinary skill in this art after training for 6 years in the intensive care unit, emergency department, and operating room actually handling and using the devices to save critically ill patients? (ordinary skill in the art). What do I know now that I am board certified by the American Board of

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Emergency Medicine and now selected as a fellow of the American College of Emergency Physicians (more than ordinary skill in the art). It is a difficult, highly selective process that takes 13 yrs after starting medical school. Mr. Stigell cannot conjecture about what ordinary skill in this art is and what a person with ordinary skill in the art might be able to develop or not, when he himself has zero skill, knowledge or actual training in this art. I welcome him to try to start the process. The basis for all of his rejections is therefore invalid and the rejections should be all removed. It has all been a house of cards- I wish I had recognized it earlier. I am very serious about this next point. I will try the matter in federal court, and Mr. Stigell can discuss how exactly he has ordinary skill in the art. I will also recover immense lost time and wages in civil court against these examiners and for what has been stated above and the reasons below.

My patent attorney and many others have said, the goal is for the examiner to prolong this as long as possible, almost always issuing a final rejection and charging another fee. The examiner ,Ted Stigell, also sent me a duplicate request for changes to the drawings after I had sent him the changes 3 months prior. The process is already frustrating and this lack of competence makes it more so. Lest he forget, I documented in an email to him which is saved and to Frederick Schmidt, the director of the entire unit and my attorneys. I called Nick Luchesi, but he does not respond to any phone calls, ever, which has been mentioned to Director Schmidt. Again, no mention of this point in the last communication. This device could save many citizens here and soldiers abroad dying needlessly from acute aspiration and lung injury caused by airway obstruction. I developed my device when a patient

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before was dying from acute airway obstruction and there was no device available to quickly remove the obstruction. I thankfully was at a large tertiary care hospital, which is one of the best staffed and equipped on earth, so we were able to take the patient to surgery and relieve the obstruction. Very few hospitals have this capability and I want them to have it because it may be you at one of these small hospitals dying from acute airway obstruction and I would like this equipment available to help these providers that do not always have the support and training to deliver this service.

The following states the remarks for traversal of the rejections which were drafted and specifically counter Mr. Stigell rejections. They are included for review.

Claims 10, 13, 14, and 16-29 are now pending in the application. Claims 18-29 have been withdrawn from consideration. Claims 11, 12, and 15 have been cancelled and the subject matter has been incorporated into Claim 10. Claim 10 as amended now recites that the reservoir includes an entry compartment and a second compartment, that the compartments are separated by a grid, and that the catheter has a diameter of from about 0.5 Fr to about 15 Fr. No new matter has been added. The Board of Appeals is respectfully requested to reconsider and withdraw the rejections in view of the amendments and remarks contained herein.

RESTRICTION UNDER 37 C.F.R. 1.142(B)